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ABSTRACT

This paper presents the objectives and results of an experimental program, the Teen Age Medical Service, in Minneapolis, Minnesota. The first objective of this program was to experiment with new ways of delivering additional, more extensive, and continuous personal services while maintaining the emergency and episodic services that have successfully evolved. Program components used in assessing movement toward this objective were: (1) a pregnancy service for teenagers which integrated medical and social services; (2) family planning services for teenagers; (3) provision for continuity of medical service for alienated or emancipated teenagers; (4) a system for community institutional coordination; (5) a medical service clinic for the poor; (6) a personalized, comprehensive medical care program for teenagers; and (7) a community health education program. Three other objectives for the Teen Age Medical Service were examined in relation to program content and quality of services. These program objectives were: (1) to develop methods of involving and employing youth in the actual delivery of health services to their peers; (2) to assist other concerned individuals and groups interested in initiating similar youth services in other metropolitan locations; and (3) to develop effective methods of integrating the findings and experience of the center into public policy. (Author/SJL)

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OBJECTIVE I "To experiment with new ways of delivering additional, more extensive and continuous personal services while maintaining the emergency and episodic services that have successfully evolved."

1. Pregnancy Service - TAMS created new team approaches and developed a new kind of nurse counselor. The TAMS' "new way" to deliver medical services for the pregnant teenager is to integrate medical and social services for the diagnosis, counseling and appropriate referral of the pregnant teenager.

   This was done by:

   A. development of the nurse counselor through training by the medical director, the head nurse, and local consultants in behavioral sciences.
   B. orientation/inservice training sessions for doctors by the medical director.
   C. utilizing a sound counseling approach.
   D. development of referral resources.

   A partial evaluation of what TAMS achieved here is possible by noting:

   A. 200 nurses trained

B. 80 M.D.'s trained

C. 2300 pregnant teenagers who received the service from July 1971 - June 30, 1974

D. that this program continues on by virtue of the momentum created by the HUD grant.

The counseling approach consists of

A. ascertain the patient's feelings and thinking regarding her pregnancy.

B. outline to the patient the feasibilities of adoption, parenthood and abortion in terms of the needs and resources social/emotional and financial, of an unborn child, the patient and the parent partner.
If patient has not involved parents and/or boy friend, staff initiates a discussion of any such possible involvement.

2. Family Planning Services

TAMS created for our community a new kind of family planning service for teenagers which proved to be very successful.
Its major elements were:

A. a unique set of planning objectives

B. a unique, for our community, service program

C. staff development

D. development of referral resources

A partial evaluation of TAMS' achievements in this service is indicated by

A. 4050 patients served (birth control class)

B. 200 nurses trained (the same nurses as for care of the pregnant adolescent)

C. 80 M.D.'s trained (the same M.D.'s as for care of the pregnant adolescent.

D. The planning objectives established by TAMS community council were

1. concern for the potential unborn child
2. concern for the teen age patient
3. that all services rendered in this area be of excellence.

The vigorous and consistent application of all of these planning objectives as the family planning service was developed resulted in community support in a very controversial area, staffing of the programs by experienced volunteer certified pediatricians and gynecologists, the development of a service program which included classes explaining the biology and psychology of reproduction and the various methods of contraception. This was followed by individual counseling which if indicated, was followed by a gynecological consultation.

Children's Health Center's mental health consultants monitored the education counseling sessions as part of the in-service training. The staff became very sensitive and helpful to the disturbed teenagers who came to these sessions because of personal psychic rather than educational needs.

3. Continuity

A reliable and acceptable continuity of medical service was a desperate need for teenagers especially those who had chronic or recurrent medical problems. Medical resources that provided continuity of service for the alienated or emancipated teenager were not available in our community.

H.E.W. funding has been the single largest factor in stabilizing the clinic. This stability has meant a very low staff turnover for both paid staff and volunteer staff. Patients now have great opportunity to see the same physician and/or nurse time after time.

Most volunteer schedules are quite regular and of course the paid staff schedules are regular, therefore the patient can even predict him/her self when "my" doctor and/or nurse will be in with a high degree of accuracy. A recent survey indicated that 13% of TAMS' patients regard TAMS as their "family physician".

4. Use of other facilities/institutions

TAMS created and developed a community multiinstitutional system that was coordinated by Teen Age Medical Service staff persons and utilized by alienated and emancipated teenagers.

TAMS referral list includes some 60 other agencies. We refer regularly to 10 - 12 of these. We have used Children's Health Center, Hennepin County General Hospital and Lutheran Deaconess Hospital for secondary care institutions referrals. (Lutheran Deaconess has a program, Early and Emergency Care, subsidized by Model City and Hennepin County making it financially available to our low income patients).

5. General medical care of the poor

TAMS created a general medical service for the poor in a clinic that served all social economic groups.

TAMS is located in a low income inner city neighborhood. This location is deliberate to serve the teens who come from families of little money. However TAMS' service in terms of clientele cannot be understood by geographical location alone. Upon opening the doors of the clinic TAMS discovered a number of teens from more affluent areas who chose TAMS for care. The overwhelming percentage of these teens gave sex-related concerns when asked for their presenting concern, "what would you like to be seen for?". The existence of Teen Age Medical Service uncovered a great need for a confidential service for adolescents from all areas. Particularly, and most obviously, is this true in cases of sex-related concerns of adolescents. What this has meant to the demographic

characteristics of TAMS' clientele is a real mixture, a true socio/economic/geographic interpretation of a clinic's patients. This means to a low-income teen that he or she has geographic and financial access to health care by virtue of being between ages 10 and 20; not because he or she is poor and thereby the target of a special charity. In so far as self concept is a part of health care, TAMS existence is a statement to poor teens that they are simply teens and have health care resources for that reason, a statement obviously true by looking at the rest of those in the waiting room.

6. Personalized Comprehensive Medical Care

TAMS created a personalized comprehensive medical care program for medically alienated and emancipated teenagers.

TAMS medical services go beyond the simplest diagnosis and treatment of the presenting concern. Many of the birth control examinations (16% of TAMS visits) are complete or near complete examinations. More than one quarter of TAMS visits include screening and over one half of TAMS exams include immunization.

7. Health Education

TAMS created a community health education program that speaks to the critical needs and interests of teenagers.

A. TAMS has developed a peer health education program called "Teen Age Health Consultants." This program grew out of TAMS' concern for teen involvement in health care.. Teens are trained to educate their peers and also to provide an information and referral service. With the cooperation of two public schools, this program has reached adolescents to date.

B. TAMS has reached out into the community with speaking engagements in PTA's, community groups, school classes and even to a class of deaf teens. This effort is 50 such engagements per year.

OBJECTIVE II "To develop methods of involving and employing youth in the actual delivery of health services to their peers".

The most visible use of teens at TAMS has been at the receptionist desk. Teens have proven themselves time and again to be willing and able to handle receptionist work. This has meant registering patients including eliciting a "presenting concern". This "Presenting concern" means an interaction between receptionist and patient requiring knowledge and sensitivity on the part of the receptionist. Likewise scheduling patients requires an interview (and interview technique).

When we speak of referral at TAMS we usually mean for continuation of counseling or treatment. However when age, geography, difficulties in patient's schedule, or nature of presenting concern indicate patients will be referred elsewhere instead of being seen by TAMS' medical staff, it is our teen receptionists who carry out this important part of our service. This is obviously most clearly an "actual delivery".

The receptionists further file medical records, record data on data forms and route telephone calls. We have also experimented with using receptionists in a task performed usually by nurses; escorting the patient to the exam room. The receptionists have ushered the patients into the exam rooms, given instructions on disrobing, provided the drape, removed lab slips from chart, written patient's name and number on culture plates and pap slides and fielded such questions as have arisen. We are of two minds on this experience. There is so much to be said for increasing the role of the para-professional, particularly in our case. Some 30 adolescents have had a paid work experience in an adolescent health care setting at Teen Age Medical Service.

The TAMS Council of course included adolescents. Theirs was a very successful involvement in the policy/decision making process of this council. The process would have been much poorer without the input of the receptionists. Their perspectives were often felt to be invaluable in determining needs and responses to need. The TAHC program (see Sec. 7, B p.5) was a direct outgrowth from TAMS and its objective "to develop methods of involving and employing youth in actual delivery of health services to their peers".

OBJECTIVE III "To assist other concerned individuals and groups interested in initiating similar youth services in other metropolitan locations."

TAMS has assisted others in initiating similar youth services by meeting with, providing training and by providing experience. The staff at TAMS has played consultant roles, has given lectures and led discussions.

1. The principal nurse and one of the founders of the West Suburban Clinic was a long time volunteer nurse at the Teen Age Medical Service.
2. One of the major founders of the NIP clinic is the wife of Dr. William Bevis, who has been connected with Chilren's Health Center for many years. Dr. William Bevis is a very active physician at the Teen Age Medical Service and one of its first medical directors. To these organizations we have provided a considerable amount of consultation time at the board, administrative level, the project director level, and medical director level in laboratory, nursing and volunteer services. There has been considerable consultation on a physician-to-physician level with those physicians interested in these two new centers.

The Family Tree Center in St. Paul, Minnesota, near Macalester College, opened last year. So far, contacts with this new clinic have been mainly with our medical, youth involvement, and administrative staff and included participation in a training program and sharing of procedures and ideas for health education.

The founders of several clinics have sought and secured consultations from TAMS in the course of setting up new clinics. These include three clinics now operating in the Twin City area:

Cedar Riverside Community Clinic

Fremont Community Clinic

The Red Door Venereal Disease Clinic of Hennepin County

The staff at TAMS have also provided both teaching and experience to the out-patient staff of the Children's Health Center - in preparation for their beginning to function as a community health service.

It is difficult to assess impact, cause and effect. TAMS is the first community clinic in the Twin Cities. (Community clinic meaning a no fee, private clinic located in its target population and involving its target population in its decision/policy processes). Since TAMS started (Fall 1968) 15 to 20 clinics have started incorporating some or all of these features and serve adolescents in toto or in part. Virtually all, if not all, have at least asked TAMS for ideas and encouragement. How many would not have started had it not been for TAMS example and/or assistance? How many are serving more adolescents than they would have without TAMS? How many are similar to TAMS in the way they provide care for teens, because of TAMS model and/or consultations? How do we measure the impact TAMS has had on efforts which did not spring directly from TAMS efforts?

Clearly we can take appreciable credit for the initiation of West Suburban Teen Clinic; likewise to only a slightly lesser degree the N.I.P. clinic. Certainly not all of the 15 to 20 clinics which have started since TAMS would have done so regardless of TAMS consultations.

While we can document a number of interactions with founders of other clinics we cannot assess the effect beyond extrapolation;

> TAMS model, consultation and encouragement preceeds the development of these services, therefore we conclude that we have played a vital role in this service development.

TAMS joined the Metro Area Community Consortium when it was formed. This consortium is a coalition of community clinics, which meet together for information sharing, coordination among themselves, common efforts in fund raising and data processing. TAMS membership as the oldest and largest community clinic was of inestimable value in establishing this coordinating, mutual assistance effort.

TAMS has given information and data to visiting groups from all over the United States and foreign countries including Sweden and Israel. Likewise TAMS has given information and data to United States Senators, the Honorable Hubert H. Humphrey, and the Honorable Walter Mondale; members of the United States House of Representatives including the Honorable Donald Fraser; the Governor of Minnesota; members of the Minnesota Legislature; the Minnesota Commissioner of Health and Minneapolis Aldermen.

Perhaps even more impressive is that TAMS developed a bacteriology service that has since been picked by the City of Minneapolis Health Department.

OBJECTIVE IV "To develop effective methods of integrating the findings and experience of the center into public policy".

The statistical evaluation system is a primary means of informing individuals and community agencies about the center.* Clinic services are reviewed by Minnesota Systems Research and reported monthly to the staff. The system is programmed to evaluate two general areas about the patient population. First, medical data on each patient is recorded and documented to determine those needs and concerns of adolescents unmet by regular health care providers. This information is distributed to local physicians, hospitals and community agencies, (e.g. Hennepin County Welfare Department, Hennepin County Board of Commissioners, Hennepin County General Hospital, City of Minneapolis Health Department, Minnesota State Health Department, Model Cities, schools and other community agencies.)

The TAMS speakers bureau continues to expand and respond to community interests. A member of the TAMS Advisory Board, who coordinates the program, provides speakers to service clubs, professional meetings, community groups, churches and schools. Discussions focus on adolescent sexuality, the free clinic movement, health care and community involvement.

TAMS has participated in the following committees:

1. Minnesota VD Awareness Committee
2. Community Health Advisory Committee (Metropolitan Health Board)
3. The National Free Clinic Council
4. The Minneapolis Consortium of Free Clinics
5. Community Health Care Meetings (Hennepin County)
6. Phillips Area Inter-Agency Council

*Enclosed Activity Report, January 1, 1973 - June 30, 1973, provided information for community planning, needs for developing new programs at and through TAMS, and for training programs for doctors and nurses at TAMS.

Perhaps most dramatically TAMS has been at least as responsible as anyone else in working with Hennepin County to make Community clinics a part of Hennepin County's health system. Seven clinics now have contracts with Hennepin County as part of a new commitment (1973) to provide "decentralized primary health care". All of these clinics serve teens and two (TAMS and West Suburban Teens) serve teens exclusively.

The Emancipated Minor Act passed by the Minnesota Legislature grew out of the TAMS' experience. TAMS staff initiated the drafting of this law by demonstrating the need for the law to the leaders of the Minnesota Public Health Association and the chief of the children's section of the State Welfare Department.

Children's Health Center and Hospital of Minneapolis, the sponsoring agency for TAMS accepted the local health planners challenge to provide for this community the desperately needed Teen Age Medical Service. The common talk in town by the health planners, public health officers, and academic leaders in the health field was that the health providers in the private sector didn't care about people who couldn't pay for their health services and volunteerism in the health field was dead. In addition to that the chief of the Minneapolis Health Department stated that there was a desperate need for health services for teenagers, yet our local university medical school, health department and county hospital had failed to mount such an effort.

The success of TAMS in the face of this sense of need and failure of other resources to rise to meet it has had a wide ranging impact of inestimable proportions. How many individuals and institutions have felt inspired or challenged by the TAMS experience?

During the HEW grant period, TAMS recorded 28,705 patient visits. Currently TAMS is continuing to grow with community funding.